CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
BBL 95-99 Observation Bed Day Group Center **Provider** **vs.** **Blue Cross/Blue Shield Association** **Premera Blue Cross/Riverbend Government Benefits Administrator/ Trailblazer Health Enterprises, LLC** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: Various** **Review of:** **PRRB Dec. No. 2003-D16** **Dated: March 6, 2003**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. The Providers submitted comments requesting that the Administrator affirm the Board's decision. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediaries' determination that the Providers had less than 100 "beds" for disproportionate share (DSH) eligibility purposes was proper.[1] The Board held that the Intermediaries' exclusions of observation bed days from the calculation of "total beds" used to determine the Providers eligibility for a DSH adjustment was not proper. Based on the governing provisions, the Board

[1] The following Providers filed this group appeal: Our Lady of Lourdes Health Center, located in Pasco, Washington; Baptist Memorial Hospital—Tipton, located in Covington, Tennessee; and, McKenna Memorial Hospital, located in New Braunfels, Texas.

found that the proper application of these governing provisions to observation beds would have resulted in the Providers' meeting the 100-available bed threshold requirement for calculation of the DSH payment. The Board concluded that the criteria applied by the Intermediaries for the exclusion of observation beds could not be supported based on the Board's interpretation of the language set forth in the regulations and manual guidelines. The fact that the beds were licensed acute care beds located in an acute care area of the Providers' facilities and permanently maintained and available for lodging inpatients were grounds that the Board found to be determinate that all of the beds at issue met the requirements for inclusion in the bed size calculation

The Board read the regulations and manual guidelines as including all beds and all bed days in the calculation, unless they were specifically excluded under the categories listed in the regulation and manual. The Board found, based on the degree of specificity with which the manual addressed this issue and the fact that the enabling regulation had been modified on at least two occasions to clarify the type of beds excluded from the count, these comprehensive rules are meant to provide an all inclusive listing of the excluded beds. The Board rejected the Intermediaries' argument that only beds reimbursed under PPS should be included in the count of available bed days since the purpose of DSH is to adjust PPS amounts. The Board stated that if this argument was valid, Congress would simply have said that in the enabling statute, and a regulation could have been easily promulgated to accommodate a category for PPS-excluded beds. Instead, the controlling regulation and manual guidelines have been written in a manner which provide great specificity regarding beds that are included and excluded from the count.

As further support, the Board relied on the example found in the PRM at §2405.3G.2, where beds certified for acute care, but used for long-term care, was included in the bed count. Finally, to further support its position, the Board cited to *Clark Regional*,[2] which held that observation beds should not have been excluded from the count for determining DSH eligibility.

[2] *Clark Regional Medical Center v. Shalala*, 314 F 3d 241 (6th Cir. 2002) reversing *Commonwealth of Kentucky 92-96 DSH Group*, Admin. Dec. No. 99-D66 November 8, 1999.

SUMMARY OF COMMENTS

The Providers commented requesting that the Administrator affirm the Board's decision similar to his affirmation in *BBL 94-98 Observation Bed Day Group*, Admin. Dec. No. 2002-D13. The Providers stated that the PRRB correctly found that the beds in questions met the regulatory and manual requirements for inclusion in the DSH calculation. To support this position, the Providers' stated that the beds in question were licensed acute care beds located in acute care areas of the hospitals and maintained for lodging inpatients. The Providers stated that, not only is this case governed by *Alhambra Hosp. v. Thompson*, 259 F.3d 1071 (9th Cir. 2001), but it is also governed by *Clark Regional*, *supra.* The Providers in this Group could appeal an adverse determination in this case to a district court in either the Ninth or Sixth Circuits.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Title VI of the Social Security Amendments of 1983,[3] adding §1886(d) to the Act, established the prospective payment system (PPS) for reimbursement of inpatient hospital operating costs for all items and services provided to Medicare beneficiaries other than physician's services associated with each discharge. These amendments changed the method of payment for inpatient hospital services for most hospitals under Medicare. Under PPS, hospitals and other health care providers are reimbursed their inpatient operating costs on the basis of prospectively determined national and regional rates for each discharge rather than reasonable operating costs. The purpose of PPS was to reform the financial incentive hospital face, promoting efficiency by rewarding cost-effective hospital practices.[4]

[3] Pub. L. No. 98-21.

[4] H.R. Rep. No. 25, 98th Cong., 1st Sess. 132 (1983).

Pursuant to §1886(d)(5)(F)(i), the Secretary is mandated to provide, an additional payment per patient discharge, "for hospitals serving a significantly disproportionate number of low-income patients…."[5]

The legislative history of COBRA 1985 shows that, with respect to hospitals that serve a disproportionate share of low-income patient, Congress found that these hospitals have "a higher Medicare cost per case."[6] Congress noted that:

> There are two categories for these increased costs: a) low-income medicare patients are in poorer health within a given DRG (that is, they are more severely ill than average), tend to have more complications, secondary diagnoses and fewer alternatives for out of hospital convalescence than other patients; b) hospitals having a large share of low-income patients (medicare and non-medicare) have extra overhead costs and higher staffing ratios which reflect the special need for such personnel such as medical social workers, translators, nutritionists and health education workers. These hospitals are frequently located in central city areas and have higher security costs. They often serve as regional centers and have high standby costs….[7]

To be eligible for the additional payment, a hospital must meet certain criteria, concerning, *inter alia*, its disproportionate patient percentage. Generally, the location and bed size of a hospital determines the threshold patient percentage amount to qualify for a DSH payment. Relevant to this case, under §1886(d)(5)(F)(v) of the Act, for the cost years at issue, a hospital that is located in an urban area and has 100 or more beds is eligible for the additional DSH payment, if its disproportionate patient percentage is 15 percent. However, if the urban hospital has less than 100 beds, it must have a disproportionate patient percentage of 40 percent to be eligible for the DSH adjustment.

With respect to the bed size, the H. R. Report explained:

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[5] Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA 1985) (Pub. L. No. 99-272). *See also* 51 Fed. Reg. 16772, 16773-19776 (1986).

[6] H.R. Report No. 99-241 at 16 (1986); *reprinted in* 1986 U.C.C.A.N. 594.

[7] *Id.*

> Based on the comprehensive analysis of cost data, the committee determined that the only hospitals that demonstrated a higher medicare cost per case associated with disproportionate share low-income patients were urban hospitals with over 100 beds…. Since the rationale for making the disproportionate share adjustment is related directly to higher medicare costs per case, the committee concluded that, based on available data, there was no justification for making these payments to … urban hospitals with fewer than 100 beds.[8]

Finally, the legislative history shows, with respect to Congress, that:

> The Committee believes that the Secretary should interpret the 100 bed threshold *narrowly*, that is, that the beds that should be counted should be staffed and available beds. The bed count would reflect beds staffed and available in the cost reporting period immediately prior to the cost-reporting period for which the adjustment would be made.[9] (Emphasis added.)

Consistent with the Act, the regulation further explains the DSH calculation at 42 C.F.R. 412.106,[10] and states that:

> *(a) General considerations.* (1) The factors considered in determining whether a hospital qualifies for a payment adjustment include the number of beds, the number of patient days, and the hospital's location.
>
> *(i) The number of beds in a hospital is determined in accordance with §412.105(b).*
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> (ii) The number of patient days includes only those days attributable to areas of the hospital that are subject to the prospective payment system and excludes all others…. (1994) (Emphasis added.)

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[8] H.R. Report No. 99-241 at 17 (1986) *reprinted in* 1986 U.C.C.A.N. 595.

[9] H.R. Report No. 99-241 at 18 (1986) *reprinted in* 1986 U.C.C.A.N. 596.

[10] Formerly 42 C.F.R. 412.118(b).

Relevant to this case is the determination of the number of beds. 42 C.F.R. 412.105(b) reads as follows:

> *Determination of number of beds.* For purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, not including beds assigned to newborns that are not in intensive care areas, custodial care beds, and beds in excluded hospital units, and dividing that number by the number of days in the cost reporting period. (1994)

Consistent with the regulations at 42 C.F.R. 412.105, the PRM at §2405.3.G provides further guidance on the methodology of counting beds for purposes of DSH.[11] The PRM states that:

> A bed is defined for this purpose as an adult or pediatric bed (exclusive of beds assigned to newborns which are not in intensive care areas, custodial beds, and beds in excluded units) maintained for lodging inpatients, including beds in intensive care units, coronary care units, neonatal intensive care units, and other special care inpatient hospital units. *Beds in the following locations are excluded from the definition* : hospital-based skilled nursing facilities or in any inpatient area(s) of the facility not certified as an acute care hospital, labor rooms, PPS excluded units such as psychiatric or rehabilitation units, postanesthesia or postoperative recovery rooms, *outpatient areas*, emergency rooms, ancillary departments, nurses' and other staff residences, and other such areas as are regularly maintained and utilized for only a portion of the stay of patients or for purposes other than inpatient lodging.[12] (Emphasis added.)

In explaining the basis for the definition of available beds as set forth in 42 C.F.R. 412.105(b), CMS stated that:

> Prior to the adoption of 412.105(b), the definition of available beds was at section 2510.5A of the Provider Reimbursement Manual—

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[11] Trans. No. 345, July 1988.

[12] *See also* CMS March 7, 1997 letter, stating that, with respect to observation beds: "if a hospital provides observation services in beds that are generally used to provide hospital inpatient services, the equivalent days that those beds are used for observation services should be excluded from the count of available beds for purposes of the IME and DSH adjustment…."

> Part I, [13] which was originally used to establish bed-size categories for purposes of applying the cost limits under section 1861(v)(1)(A) of the Act….
>
> In the September 3, 1985 final rule, we added the definition of available beds to the regulations governing the IME adjustment (then 412.118(b)). The expressed purpose for the change was to stop counting beds "based upon the total number of beds available on the first day of the pertinent cost reporting period" and to begin counting based on "the number of available bed days (excluding beds assigned to newborns, custodial beds, and beds in excluded units) during the cost reporting period divided by the number of days in the cost reporting period (50 FR 35679). We did not change the definition of available beds. *Our current position regarding the treatment of these beds is unchanged from the time when cost limits established under section 1861(v)(1)(A) of the Act were in effect and is consistent with the way we treat beds in other hospital areas. That is, if the bed days are allowable in the calculation of Medicare's share of inpatient costs, the beds within the unit are included as well.*[14] (Emphasis added.)

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[13] Section 2510.5.A of the PRM, as drafted in 1976, stated: *Bed Size Definition*. For purposes of this section, a bed (either acute care or long-term care is defined as an adult or pediatric bed (exclusive of a new-born bed) maintained for lodging inpatients, including beds in intensive care units, coronary care units, and other special care inpatient hospital units. Beds in the following locations are excluded from the definition: beds in sub-provider components, hospital-based skilled nursing facilities or beds located in any non-certified inpatient area(s) of the facility, beds in labor rooms, postanesthesia or postoperative recover rooms, outpatient areas, emergency room, ancillary departments, nurses' and other staff residences and other such areas which are regularly maintained and utilized for only a portion of the stay of the patients or for purposes other than inpatient lodgings.

[14] 59 Fed. Reg. 45330,45373 (1994). *See also Id.* at 45374 (With respect to the inclusion of neonatal beds in the count: "[W]e believe it is appropriate to include these beds because the costs and the days of these beds are recognized in the determination of Medicare costs, (nursery costs and days, on the other hand, are excluded from this determination)…." (Emphasis added.) The *Federal Register* is the vehicle recognized under 5 USC 552(b) for providing notice and comment when formal rulemaking is undertaken.

Consequently, CMS has a longstanding policy of only considering bed days in the bed count if the costs of such days were allowable in the determination of Medicare inpatient costs. This did not mean that CMS policy requires that the bed day in fact must be paid by Medicare, as the *Alhambra* court suggests. Rather, the bed day must be used in the calculation of Medicare's share of the costs. Under reasonable cost, the average cost per day for reimbursement purposes is calculated by dividing the total costs in the inpatient routine cost center by the "total number of inpatient days." Medicare reimbursement for routine inpatient services is based on an average cost per day as reflected in the inpatient routine cost center multiplied by the total number of Medicare inpatient days. Early in the program, an inpatient day was defined as a day of care rendered to any inpatient except a newborn. Consequently, a bed day included in either the total number of Medicare days (for example, if for a Medicare hospital inpatient) or the total number of inpatient days (including both Medicare and nonMedicare hospital inpatients) would impact the Medicare per diem payment. Notably, PPS was implemented to replace the reasonable cost method of reimbursing hospitals for the operating costs of inpatient hospital services, but continued to require cost reporting consistent with that required under reasonable cost. Thus, CMS maintained a consistent policy in defining available beds throughout the change from a cost-based inpatient hospital payment system to a prospective-base inpatient hospital payment system.

As CMS noted, this interpretation of available beds is also consistent with that aspect of DSH eligibility concerning the determination of the patient percentage calculation, under 42 C.F.R. 412.106(a)(1)(ii). CMS explained that in determining DSH adjustment:

> [W]e believe that, based on a reading of the language in section 1886(d)(5)(F) of the Act, which implements the disproportionate share provision, *we are in fact required to consider only those inpatient days to which the prospective payment system applies in determining a prospective payment hospital's eligibility for a disproportionate share adjustment. Congress clearly intended that a disproportionate share hospital be defined in terms of subsection (d) hospital, which is the only type of hospital subject to the prospective payment system* ….
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> Moreover, this reading of section 1886(d)(5)(F) of the Act produces the most consistent application of the disproportionate share adjustment, since only data from prospective payment hospitals or from hospital units subject to the prospective payment system are used in determining *both* the qualifications for and the amount of

> additional payment to hospitals that are eligible for a disproportionate share adjustment.[15] (Emphasis added.)

Thus, CMS requirement that a bed under 42 C.F.R. 412.105(b) only be included in the DSH bed count calculation when the costs of the day are recognized as an inpatient service cost is also consistent with the inclusion of only "inpatient days to which the prospective payment system applies" in determining a PPS hospital's eligibility for a DSH adjustment. The Administrator finds that, contrary to the Board's contention, as the legislative history clarifies, the DSH adjustment is intended to be an additional payment to account for a higher Medicare payment per case for PPS hospitals that serve a disproportionate number of low-income patients. Accordingly, it is proper to determine a PPS hospital's eligibility for this additional payment based on bed, which are recognized as part of the PPS hospital's inpatient operating costs.

The Providers contend that observation beds should be included in the bed count for purposes of determining DSH eligibility. The Providers maintain that the beds at issue are licensed acute care beds located in the acute care area of the hospital and maintained for inpatient lodging. The beds were used for outpatient services only when not in use for inpatient care services. If these beds are included in the calculation of the Providers' bed size, they each will have over 100 beds.

Regarding observation bed days, the Administrator finds that a patient in an observation bed has not been admitted into the hospital. The payment of observation bed days as outpatient services is consistent with §230.6 of the Hospital Manual, which provides that:

> *A.* *Outpatient Observation Services Defined*.—Observation services are those services furnished by a hospital on the hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and to evaluate an outpatient's condition or to determine the need for a possible admission to the hospital as an inpatient….
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> B. *Coverage of Outpatient Observation Services*.—Generally, a person is considered a hospital inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least over night … *When a hospital places a patient under observation, but has not formally admitted him or her as*

[15] 53 Fed. Reg. 38476, 38480 (Sept. 30, 1988); *see also* 53 Fed Reg. 9337 (March 22, 1988).

> *inpatient, the patient initially is treated as an outpatient ….* (Emphasis added.)

Consistent with the payment of these services as outpatient services, §3605 of the PRM-Part II explains that the costs of observation bed patients are to be carved out of the inpatient hospital costs. Line 26 of §3605.1 explains that "observation bed days only need to be computed if the observation bed patients are placed in a routine patient care area. The bed days are needed to calculate the costs of observation bed days since it cannot be separately costed when the routine patient care area is used. If, however, you have a distinct observation area, it must be separately costed (as are all other outpatient cost centers), and this computation is not needed." Consequently, consistent with the treatment under earlier reasonable cost methodology, the observation bed days are not recognized and paid under inpatient hospital PPS as part of a hospital's inpatient operating costs and are not included in the count for bed size.

In addition, in contrast to the Board's conclusions, courts have rejected earlier attempts by providers to argue that 42 C.F.R. 412.105(b) is an all-inclusive list. Instead, the Secretary was faced with similar arguments concerning neonatal intensive care beds and was successful in arguing that the regulation as written at that time did not clearly exclude all beds assigned to newborns, but could reasonably be interpreted to apply only to newborns in bassinets. The neonatal intensive care beds at issue in those cases were more like intensive care beds, which were listed as beds to be counted, and less like newborn bassinets, which were listed as beds to be excluded.

Indeed, contrary to the Board's narrow reading of 412.105(b) and the manual as an all inclusive list, courts have found that the list is not confined to the literal terms of 412.105(b) in assessing its meaning. *See*, e.g., *AMISUB d/b/a/ St. Joseph's Hospital v. Shalala*, No. 94-1883(TFH) (D.D.C. 1995); *Grant Medical Center v. Shalala*, 905 F. Supp. 460, 1995 U.S. Dist. Lexis 17398; *Sioux Valley Hospital v. Shalala*, 29 F.3d 628,1994, U.S. App. Lexis 26519. The language of 42 CFR 412.105(b) with respect to neonatal intensive care beds was ambiguous and, thus, the Secretary's interpretation was entitled to deference.

Similarly, the Administrator finds that the listing of beds to be excluded in the regulation and the PRM is general in nature and not all-inclusive. A review of the beds listed to be excluded from the count of bed days shows such beds to be, *inter alia*, not paid as part of the hospital inpatient operating PPS payment. The observation beds at issue, which are being used for outpatient beds, are more like

those beds located in the outpatient area. The Administrator notes that CMS has been consistent, as mandated by the regulation, in its policy for counting bed days in determining a provider's number of beds under 42 C.F.R. §412.105(b), whether for the indirect medical education adjustment or the DSH adjustment and have consistently excluded from that count bed days not paid under inpatient hospital PPS.[16] CMS observed that:

> Our policy to include the costs, days and beds of neonatal intensive care units has been in place since prior to the prospective payment system and has been the subject of considerable attention. We believe we have a responsibility to apply this policy consistently over time and across providers. Excluding these beds from the determination of bed size would have an adverse impact on some hospitals. Several prospective payment system special adjustments are based on bed size: for example the threshold and adjustment for the disproportionate share (DSH) adjustment for urban hospitals with 100 or more beds. If we no longer considered neonatal intensive care beds in determining bed size, DSH adjustments to some hospitals would be sharply reduced….[17]

The Board's reading is also inconsistent with the Congressional intent that the DSH payment be an additional payment for "subsection (d)" hospitals, i.e., PPS hospitals, higher medicare "costs per case." The higher medicare cost per cost necessarily reflects higher inpatient costs. Thus, CMS has reasonably used "inpatient hospital" bed days as the measure for the DSH adjustment.[18] Finally, the Administrator finds that the Board's conclusion that the beds issue are available for inpatient lodging is inconsistent with the fact that the beds were being used to maintain outpatients for the bed days at issue.

However, the Providers' also argue that the beds at issue in this case are analogous to beds in *Alhambra* and thus that court's ruling should be controlling under the facts in this case. In *Alhambra*, the court addressed the particular language of 42

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[16] The Administrator finds that the Board's statement that the regulation does not require that beds be counted the same for DSH and IME is directly contrary to the regulation.

[17] 59 Fed. Reg. 45374.

[18] At this time, neither Congress, nor CMS, has extended a DSH-type payment beyond inpatient hospital PPS. Notably, CMS decided not to pay a DSH adjustment under outpatient PPS because the estimated effect on the DSH patient percentage on costs was small and most often statistically insignificant. 64 Fed. Reg. 35260.

CFR 405.106(a)(1)(ii) which refers to the number of patient days attributable to the "area" of the hospital that is subject to the prospective payment system, and excludes all others. The court focused on the specific language of the regulation referring to "areas" of the hospital and found that such a "definitional boundary chosen by HCFA is geographic."

The court found that all covered inpatient hospital services are presumed to be covered under PPS, unless they meet specific requirements for an exception. The court concluded, under the facts of that case, a SNF that fails to comply with the strict requirements for exemption is subject to PPS. The court also addressed and rejected the Secretary's contention that the bed days must be a subsection (d) inpatient hospital bed day to be included in the DSH calculation and that the beds should otherwise be excluded when they are not inpatient hospital bed days. Instead, the court found that the regulation by its terms requires the analysis of particular units and, where the bed is located in a unit not specifically excluded under the regulation, the bed is properly included in the calculation.

The Administrator recognizes that under section 1878(f)(1) of the Act, the provider group can file in a judicial district located in the Ninth Circuit. The Administrator finds that the type of bed and the controlling regulation is distinguishable from that presented in *Alhambra*. However, the court's definition of the term "areas" within the context of "geographical" boundaries of the hospital for DSH purposes, as opposed to a definition within the context of cost reporting requirements, is similarly problematic in this case. The court's inflexible "all-inclusive" approach to interpreting the CMS' regulation is also similarly problematic in this case.

In this particular case, the bed days at issue were carved out of the calculation of the inpatient hospital routine costs as an outpatient cost, but the beds were not geographically located in outpatient area of the hospital. Instead, the beds were geographically located in the inpatient care area of the hospital. Moreover, while the regulation does not refer to "areas" of the hospital, the manual in providing more specific examples of the beds to be excluded from the bed count, refers to the exclusion of beds located in, *inter alia*, outpatient "areas."[19]

[19] In addition, as the Secretary requires that the DSH bed size and the IME bed size be determine in accordance with the same rules, to the extent that the Secretary's policy for counting bed days has been modified in this case by the *Alhambra* decisions for DSH bed size, it is similarly modified for determining IME bed size.

The Providers' also cite to *Clark Regional*, *supra*, for support that observation beds should be included in the Providers' DSH adjustment. The Court of Appeals in the Sixth Circuit in *Clark Regional* ruled in favor of those providers on the issue of whether observation bed days may be included in the calculation of available bed days for purposes of the DSH adjustment. Under section 1878(f)(1) of the Act, the provider group can also file in a judicial district located in the Sixth Circuit.

As these cases are binding in the circuit in which the Providers are entitled to seek judicial review, the Administrator hereby affirms the Board's decision and reverses the Intermediary's adjustment with respect to observation bed days. The Board's decision is affirmed only on the limited grounds that there is binding law in the Sixth Circuit that observation bed days should be included in the DSH available bed day calculation and that there is binding law in the Ninth Circuit that for DSH bed days purposes the term "area" is defined within the context of the geographical location of the bed. This decision is limited to the facts, circumstances, and cost years presented in this specific case. The decision does not affect the Secretary's ability to continue to defend this issue in other circuits, or further clarify his definition of bed size and available beds consistent with his longstanding policy.

DECISION

The Board's decision is affirmed, but only on the limited grounds that in the circuits in which the provider group can file suit, there is adverse case law relevant to the pertinent facts and law of this case. The decision is limited to the facts and circumstances of this case and to the cost years at issue.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 5/5/03

/s/
Leslie V. Norwalk, Esq.
Acting Deputy Administrator
Centers for Medicare & Medicaid Services